Medicare reimbursement, allowable procedures at forefront of ASC challenges

Leaders of ambulatory surgery centers (ASCs) can expect to continue facing challenges related to reimbursement even as they try to increase the kinds of procedures that can be performed in their facilities, say experts with the Ambulatory Surgery Center Association (ASCA). Other key factors that will determine their future success include quality measurements, facility design requirements, and use of electronic health records (EHRs).

“Our number one regulatory and legislative goal is to move ASCs off the CPI-U [Consumer Price Index for All Urban Consumers] factor,” Steve Miller, ASCA’s director of government and public affairs, told OR Manager. That’s one reason the association is working to pass the Ambulatory Surgical Center Quality & Access Act of 2013 (H.R. 2500/S. 1137). The bill has more than 60 cosponsors, but given the current legislative gridlock, Miller thinks passage this year is unlikely.

The bill focuses on how ASCs are reimbursed and how the Centers for Medicare & Medicaid Services (CMS) decides on which procedures an ASC can perform (http://www.ascassociation.org/ASCA/GovtAdvocacy/Legislation/ASCQualityAccessActof2013). The main goals of the bill are to:

- Change the ASC update factor from the CPI-U to the more appropriate Hospital Market Basket Index.
- Establish a value-based purchasing program that saves Medicare money and provides a bonus pool to ASCs that meet certain quality standards.
- Direct CMS to add a representative of the ASC community to be appointed to the Advisory Panel on Hospital Outpatient Payment, which helps determine ASC facility fees and which procedures Medicare will reimburse ASCs for providing.
- Create more transparency within the Medicare procedure approval process by requiring CMS to disclose which of six criteria triggers the exclusion of a procedure from the ASC-approved list.

Reimbursement and procedures

“There is an increasing discrepancy between what Medicare pays to a hospital outpatient department and an ASC,” says David Shapiro, MD, past president of ASCA and a member of the ASC Quality Collaboration Board of Directors. He adds that he tells legislators, “Patients will receive the same care, with the same equipment, with the same surgeon, at two different sites that might be across the street, but Medicare pays about twice the amount for the hospital-based procedure.” That’s why ASCA is working to have CMS base annual ASC reimbursement updates on the Hospital Market Basket Index instead of the CPI-U.

Increasing the number of procedures performed in an ASC can boost revenue, but expanding the list can prove difficult, particularly because those outside CMS don’t know how the agency decides which procedures to add to the annual list.

“We need transparency in the procedure approval process,” says Miller. “We don’t know why a procedure isn’t allowed to be done.”
Currently Medicare reimburses hospital outpatient departments (HOPDs) for performing about 360 procedures that it will not reimburse ASCs for providing to its beneficiaries. Because CMS doesn’t give a reason for denying a procedure in the ASC setting, ASCs can’t refute these decisions. Shapiro notes that sometimes private payers may, unfortunately, look to the CMS list when deciding what they will reimburse, creating additional reimbursement headaches for ASCs.

On the other hand, Shapiro says, “Some private payers have been more progressive as to what they’ve allowed ASCs to perform, so when it comes to Medicare beneficiaries, we’re faced with the ability to safely perform a procedure on someone who is 64 years old, but we can’t do the same procedure on someone who is 65 years old because of CMS constraints.” Yet, he notes, certain procedures could safely be performed at an ASC for a significantly lower cost compared to hospitals.

“Moving more procedures into the ASC is going to be a major push of ours over the next several years, not just on the Medicare side, but on the commercial side, too,” Miller says. For example, he notes that total hip, total knee, and spine procedures are being done every day as outpatient procedures, but CMS limits nearly all of them to inpatient procedures. (Some spine surgeries are permissible in an ASC.)

What’s more, private insurers are already paying for many of these procedures. Miller acknowledges that not every patient is suitable for undergoing surgery in an ASC, but allowing healthy patients access to ASCs could save CMS millions of dollars.

Reaping the benefits of savings
Currently ASCs receive reimbursement from CMS of about 55 cents on the dollar in comparison to HOPDs for the same procedure. Moreover, ASCs don’t receive any of the savings that they generate for the Medicare program. That’s why the ASC Quality & Access Act of 2013 includes a provision for value-based purchasing that would allow ASCs to share in cost savings.

“ASCs generate substantial cost savings of about $2.5 billion a year, and we think centers should share in that,” Miller says. In the proposed plan, CMS would set a spending goal for procedures eligible to be performed in an ASC. If spending on those procedures fell below the target, the difference would be in a savings pool. Half of any money saved would be returned to CMS, and the rest would be used for bonuses for high-performing facilities or for facilities that demonstrated the greatest increase in quality.

“You want to incentivize people to do the right thing,” Miller says. “If you reward only the highest performance, it may become a disincentive for facilities to try to improve their quality.”

Miller cites a recent success story in working with CMS. The agency was requiring radiologists to sign off on paperwork related to imaging, so ASCs had to pay a radiologist to simply sit and sign papers, even though surgeons and other ASC employees are qualified to perform this task. ASCA was able to convince CMS to drop the radiologist on staff signature requirement, which CMS estimates will save ASCs $41 million every year.

Quality and satisfaction at the forefront
Unlike hospitals, ASCs don’t use HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems), but that doesn’t mean quality isn’t a focus, particularly given the new quality reporting requirements from CMS.

Several years ago, ASCA assembled a group of stakeholders who identified possible quality measures for ASCs that could be discussed with federal regulators. These
include patient burn, patient fall, hospital transfer and admission, and wrong site/patient/procedure/implant surgery.

Other possible measures followed, including prophylactic IV antibiotic timing, safe surgery checklist use, facility volume data on selected ASC surgical procedures, influenza vaccination coverage among healthcare workers, appropriate follow-up interval for endoscopy/polyp surveillance, and avoidance of inappropriate colonoscopy interval for patients with a history of polyps.

Since then, CMS has also proposed some other quality measures. “We’re not really happy with all of them, but we’re working on getting some modified and developing other measures of quality,” Miller says.

Part of the problem is that many of the regulations don’t fit with the ASC care model. For example, CMS added a requirement that patients undergoing cataract surgery in an ASC undergo a visual field analysis 90 days after the procedure, but, of course, by then patients are long gone from the ASC. In its proposed ASC payment rule for 2015, CMS is recommending that this reporting measure be made voluntary.

“Especially since physicians are already being asked to report this information (results of a visual field analysis 90 days after the procedure), we think this proposal is a step in the right direction,” adds Miller.

Shapiro notes that when it comes to customer satisfaction as a measure of quality, ASCs have a distinct advantage: “ASCs are very customer focused. It’s one of the areas where we have thrived.”

Unfortunately, measuring customer satisfaction has varied across states. Shapiro says that CMS is currently piloting a new customer satisfaction survey and estimates that it will be implemented within a year.

“It remains to be seen how CMS mandates the reporting of the instrument,” he adds. He anticipates that the first proposed ruling will require reporting in 2015, with a link between amount of reimbursement and customer satisfaction established in 2016.

Facility design requirements
ASCs are also affected by the 2014 Guidelines for Design and Construction of Hospitals and Outpatient Facilities released by the Facility Guidelines Institute (FGI). Here is a summary of new requirements related to ASCs:

• The minimum OR size in the outpatient setting is 250 sq ft, which replaces classification of OR size based on anesthesia use. What used to be called Class A rooms are now procedure rooms, and the minimum size is 150 sq ft. Endoscopy rooms have a minimum size of 200 sq ft.

• The minimum number of required Phase I postanesthesia care unit patient care stations is 1.5 per OR.

• At least one scrub station must be next to the entrance of each OR. (A scrub station with two scrub positions may serve two ORs as long as it’s located next to the entrances.)

• A 44.5-inch clear opening is now required for doors that may be used for wheeled-bed stretchers.

(For more information about the guidelines, see OR Manager, July 2014, pp 1, 7-11).

EHRs
ASCs weren’t included in the Health Information Technology for Economic and Clinical Health (HITECH) Act, so they weren’t eligible for bonuses or penalties related to EHRs. Unfortunately, those exclusions also meant that they weren’t
given any incentives to implement EHRs. “That’s why products designed for ASCs haven’t been developed in the marketplace,” Miller says.

ASCA is working with federal regulators on a voluntary certification program for EHRs in ASCs. An ASCA task force has made recommendations that were approved by the ASCA board. The next step is to seek approval from the National Office of Co-ordinator for IT to make these criteria part of a voluntary certification program. “We think it’s important because information needs to be accessible in all settings so there is a complete health record,” Miller says.

Be aware
ASC leaders will have their hands full keeping abreast of upcoming initiatives, and it’s essential to stay informed. Shapiro advises ASC managers to get involved in the formation of accountable care organizations (ACOs) in their regions.

“ASCs have proven to be the flagship for providing the type of healthcare that ACOs aspire to: cost-effective, high-quality, patient-centered care,” he says. “To the extent that ASCs are part of ACOs, they will find themselves a place in that community; if they are not at the table, they could just as easily be left out of healthcare provided in the community.”

Shapiro suggests ASC leaders talk to surgeons, hospitals, and payers about developments and be visible. For example, suppose there are two ASCs in a community. A hospital looking to buy an ASC to help reduce costs as part of an ACO will choose the one that has already established a relationship with the hospital. “The other will be left to languish if there aren’t a significant number of independent practitioners to sustain it,” Shapiro says.

“There is still a great deal of uncertainty regarding how Obamacare will work in practice,” he adds. “That book is yet unwritten, and for ASCs there’s still a lot of uncertainty.” He emphasizes that ASC leaders must be most aware of what consolidation is occurring at the local level.

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